STATE OF WASHINGTON
Department of Social and Health Services

Mental Health Division
Health and Rehabilitative Services Administration

Strategic Plan
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Division Overview

The Mental Health Division (MHD) operates an integrated system of care for people with mental illness who are enrolled in Medicaid and for those who are low income and meet the statutory need definitions. MHD is committed to the belief that it is both necessary and possible to create a seamless system that can respond to consumers' needs in a cost effective and efficient manner.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act consolidating responsibility and accountability for individuals' community mental health treatment and care through Regional Support Networks (RSNs) including crisis response and management of the involuntary treatment program. Beginning in October 1993 through 1996, MHD implemented capitated managed care for community outpatient mental health services through a federal Medicaid waiver creating prepaid health plans operated by the Regional Support Networks. In 1996, the waiver was amended to include community inpatient psychiatric care and, by 1999 all Regional Support Networks were responsible for management of inpatient community mental health care.

The business of the publicly funded mental health system is to meet the needs of individuals it serves while ensuring the safety of both the individual and the community. The MHD has built upon regional partnerships to create the best service standard possible from two major models of service:

- **Public Mental Health** – historically this model has provided care for those who are most at risk and least able to access other sources of services.
- **Private sector managed care principles and tools** – provide clarity, accountability, utilization management and fiscal alternatives to the continuing challenge of escalating costs in public mental health.

The mental health system strives to take the best practices that private managed care has to offer and combine those with the core values of the publicly funded mental health system. This model ensures access to services that meet individual needs, provision of community linkages, and integration of other publicly funded services and natural supports in the most cost effective, responsive manner.

MENTAL HEALTH DIVISION CORE VALUES ARE:

1. We value the strengths and participation of consumers and their families.
2. We value the cultural and diverse qualities of each consumer.
3. We value our partners in delivering quality, cost-effective and individualized services.
4. We value practices that support consumers in their recovery and that maintain people at their highest possible level of functioning.

Mission Statement

The Mental Health Division Administers A Public Mental Health System That Promotes Recovery And Safety.

Principles

- Individuals are actively involved in and determine the design and implementation of their service plan.
- Individuals have access to a system of comprehensive and integrated community based services.
- Services promote natural and community supports including family, friends, and other citizens.
- Services demonstrate respect for rights and dignity of all individuals.
- Services incorporate the culture and value system of the individual.
- Individual choice, satisfaction, safety, and positive outcomes are the focus of services.
- Individuals are offered the support and services necessary to be successful where they live, work, and play.
- Services are designed to foster communities where all members are included, respected, and valued.

Statutory Authority References

Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.

Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

Chapter 71.24 RCW - Establishes community mental health programs through county-based regional support networks that operate systems of care.

Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.

Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.

Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.

Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies.

Appraisal of External Environment

The public mental health system serves consumers in community settings and in state owned and operated hospitals. The mental health system is responsible for the care of low income adults and minors, operation of a crisis response system for all of Washington's citizens, administration of the Involuntary Treatment Act, crisis response in times of disaster, regulation of mental health providers and development of mental health policy. The mental health system exists in a rapidly changing and complex environment.

The community mental health system operates under Chapters 71.24, 71.05, 38.52, 74.09 and 71.34 RCW and under a 1915b Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model. Under managed care, Regional Support Networks (RSNs) enter into full risk prepaid health plan contracts with the state to operate a prepaid health plan that provides community inpatient and outpatient services to Medicaid eligible persons.

The contract gives RSNs responsibility for services described in state statute. These services include community support, employment, and residential services for persons meeting statutorily defined categories.
Community support services are described in Chapter 71.24 RCW but must cover at least the following:

- Emergency crisis intervention services;
- Case management services;
- Psychiatric treatment including medication supervision;
- Counseling and psychotherapy services;
- Day treatment services as defined in Chapter 71.24 RCW; and,
- Consumer employment services as defined in Chapter 71.24 RCW.

With regard to residential and housing services the Regional Support Network ensures:

- Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.
- The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the

community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in Chapter 71.24 RCW.

- That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (Chapter 70.129 RCW).

RSNs coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services described in Chapter 71.24 RCW and assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect income and benefits the consumer is receiving because of their disability;
- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-discrimination law.

Additionally, RSNs administer the involuntary treatment program and the crisis response system for the citizens of the state of Washington in their catchment area. In most communities, crisis and involuntary services are highly integrated. The mental health system and the RSNs operate the only behavioral health crisis system in the state resulting in responsibility by default for conditions not normally considered as mental illness. These crisis services are available to all citizens, regardless of income.

Crisis services include a 24 hour per day crisis line and in person evaluations to the people of the community presenting mental health crises. Crises are to be resolved in the least restrictive manner and should include family members and significant others as appropriate to the situation. In addition, RSNs ensure access to other necessary services such as medical services and medication, interpretive services, staff with specialty expertise, and access to the involuntary treatment program.

Involuntary treatment services, as part of crisis services, are available in all of the communities of the state 24 hours per day. These services include in-person evaluation of the need for involuntary psychiatric hospitalization. General criteria for such involuntary services include danger to self, to others, or to property caused by a mental disorder – danger or a mental disorder alone are not enough for a person to lose their rights to make decisions about their own care. Both must exist and the danger must be as a result of the mental disorder. While local decisions related to detention are made by community based involuntary treatment staff, actual commitment decisions are made by state courts. Individuals needing involuntary care receive it in hospitals or evaluation and treatment facilities or in one of the three state-operated psychiatric hospitals or in one of the CLIP Residential Treatment Facilities for Psychiatrically Impaired Youth.

As prepaid health plans, the RSNs provide community mental health services described in the State Plan. A few of these services include:

- Face-to-face treatment activities designed to help the consumer attain goals as prescribed in the consumer's individual treatment plan. These services shall be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, work or educational environments. These services may include, but are not limited to: developing the consumer's independent self care skills; monitoring and supervising of the consumer's functioning; health services; counseling and psychotherapy.
- Prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services.
- Hospital diversion services which are a less restrictive alternative to inpatient hospitalization, or are a transitional program after discharge from inpatient services. These services are designed for persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. These services include a mix of individual, group services and crisis services.

These services are funded according to the number of Medicaid eligible persons living in each RSN's catchment area. The funding mechanism does not necessarily mirror demand for mental health services, since community mental health service demand tends to be stable as Medicaid caseloads vary. A strong economy does not decrease the need for mental health services and a slower economy may not indicate a large increase in the need for services.

As prepaid health plans, RSNs authorize and pay for community inpatient psychiatric care for residents in their catchment areas. As Medicare and private insurance continue to cut costs by trimming services and rates,

community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards, and the public mental health system is forced to deal with unmet demand. This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs. The threatened lack of community inpatient capacity and perceived funding shortfalls have caused RSNs to think about alternative ways to serve patients appropriately, while maintaining cost effectiveness and quality.

As in all of health care, community based, outpatient services are generally the first and most desirable set of services for dealing with health conditions. When acute situations arise or when outpatient services do not succeed, inpatient hospital care often becomes necessary.

The Mental Health Division owns and operates two adult psychiatric hospitals and one psychiatric hospital for children. Overall, these hospitals provide care for approximately 1,300 adults and 47 children each day. The state continues to grapple with higher demands for patient care from the courts, the legislature, CMS and the accrediting organization (Joint Commission of Accredited Healthcare Organization). The Mental Health Division also holds contracts for the operation of four children's long-term inpatient programs (CLIP). These facilities along with the children's psychiatric hospital provide capacity for 96 children statewide.

Within the adult hospitals, there are two systems of care – civil and forensic. Patients can enter the civil wards of the hospital through a voluntary admission or through an involuntary civil commitment. There are processes whereby a patient may be civilly committed upon being discharged from the criminal justice system, or patients may be civilly committed without entering the criminal justice system. State hospital civil capacity is an integral part of the community's resource for treating persons with mental illness. As such, the RSNs are responsible for maintaining their use of state hospital capacity within contractual limits. The state is moving toward placing further responsibility for state hospital capacity with the RSNs in a measured fashion.

Patients enter forensic (legal) wards through the criminal justice system. Services provided are generally evaluations, restoration of competency to stand trial, and care of those found not guilty by reason of insanity. State hospital forensic census is controlled by criminal law changes and court action. The most significant impacts on forensic services have come about as a result of recent legislation affecting offenders with mental illness. These laws have generally increased the number of persons served by the forensic units at the hospitals and have resulted in some services being performed at community jails.

Loss of State Funds Without a Reduction in Requirements

Throughout the past several years, state-only funds have not kept pace with the required responsibility of the mental health system. The system is responsible to provide medically necessary mental health services to persons meeting the statutorily defined public client. Conflict arises in funding with the perception in differences in the population defined in statute and the population defined by Medicaid, the other major public system funding source. Medicaid requires services to a much broader group of people.

While some services and persons seeking services are the same, others are not. The system is also responsible for crisis and involuntary treatment services to the general population, to provide the room and board costs associated with community residential care and to provide assistance with employment. These services are not Medicaid reimbursable. As noted elsewhere in this document, the Mental Health Division pays a capitation rate to the Regional Support Networks. It is not possible at this time for the division to track the costs of these state-funded services. As such, each budget cut to state funds has further reduced funding available to provide services to non-Medicaid population or to provide the services defined in statute.

Another contributing factor is state fund reductions in other programs which result in reduction of mental health services provided by these allied systems- Children's Administration, Aging and Adult Services Administration, Division of Developmental Disabilities, Division of Alcohol and Substance Abuse, Office of the Superintendent of Public Education, Juvenile Rehabilitation Administration and the Department of Corrections to name a few. These services are still needed by department clients, and allied systems believe these services are then required to be provided by the RSNs. State funding for these services, however, does not follow to RSNs again requiring them to do more with less.

Coordinated Services for Children

Between nine percent and thirteen percent of children (age 9-17)[1] have serious emotional disturbances that effect their functioning in family, school or community activities. There are an additional number of children identified by the school system as having serious behavioral disability. These children are served not only by the mental health system and the school system but often times by the Children's Administration, Juvenile Rehabilitation Administration, Medical Assistance Administration, Division of Alcohol and Substance Abuse, and/or Department of Health. It is the responsibility of the mental health system to educate the public on mental health issues: in particular, to provide information substantiating that children may not be seriously emotionally

[1] The Future of Children, Summer/Fall 1998

disturbed, but have other issues in their lives that effect their behavior bringing them to the attention of the community.

It is important that care coordination exists for these children and their families. The family should not have the additional burden of coordinating with multiple systems that assist them. To the contrary, the systems should work together to serve the child. It should also not be necessary for parents to relinquish custody and care of their children to get services they need.

A growing informal network of parents and others is being noticed by allied systems of the mental health structure resulting in an increasing number of conversations in other programs about the utilization of parents, neighbors and friends. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to deal with children with serious emotional or behavioral needs. Although this network has become more accepted by providers and as their community involvement expands, they however are not yet universally seen as a resource. This group, however, has a strong belief in their role as a system partner and will continue to be involved as coordination continues to grow. One way this coordination is happening is through the former Parent Council, supported by the Mental Health Division. The Parent Council renamed the Statewide Action for Family Empowerment of Washington (SAFE-WA) has recently become the recipient of a SAMHSA grant to be the statewide parent/family network. SAFE-WA has representation from all of the recognized parent advocacy and support groups and meets quarterly to bring a united voice to the Division's management.

Over the course of many biennia, training and technical assistance on the use of innovative methods of cross-system partnerships to deliver this coordinated care have been provided. In addition, numerous local and national reports on coordinated care and best practice have been written. What has not happened is the funding and high level commitment in all systems of care to support the process.

Community Inpatient Capacity and Cost

Washington hospitals are facing financial hardship and curtailing services in many communities. In February 2000, the state Department of Health reported that hospitals had the lowest net income for any annual period since the state began to collect hospital financial information more than 40 years ago.

Hospital costs continue to rise but reimbursements have not kept pace. New life saving technologies – including pharmaceuticals – improve patient care but cost more, and the additional costs are typically not reimbursed by all insurers.

Hospitals are experiencing a worsening shortage of nurses and other medical personnel. Costs of recruitment and retention are increasing rapidly.

The 1997 Federal Balanced Budget Act cut more than $1 billion in payments to Washington State's community hospitals from 1998-2002.

The 2000 state legislative session provided clear evidence that the combined effects of the I-601 spending limit, the significant loss of revenue as a result of I-695, and increased demands for education and transportation dollars will continue to place the state's health care budget in serious jeopardy of erosion.

Hospital operating margins have plummeted to dangerous, historically low levels. Low margins often force hospitals to curtail services, while inhibiting investment in new medical technologies or renovation of aging buildings and facilities. Hospitals experiencing years of low or negative operating margins face an uncertain future including, in some cases, the threat of closure. This despite the fact that this state's community hospitals are among the nation's most efficient and low-cost.

Recent years have been marked by significant changes in the mental health inpatient service delivery system. There has been planning and implementation for greater use of community hospitals for in-patient psychiatric services. For many, there has also been a realization that significant additional funding for mental health services will not be forthcoming.

Hospitals that would once take psychiatric patients through the Medicaid system no longer will, or in the worse case scenario, these community hospitals have closed their doors completely.

Trends in Customer Characteristics

Mental health consumers include Medicaid eligible persons, low-income persons not eligible for Medicaid, and all citizens of the state (for crisis services).

Chart 1 shows the Medicaid population accessing mental health services over the last three biennia is fairly stable. In FY 2001, 118,321 people—70,723 of them Medicaid covered—utilized mental health services in community outpatient settings.

Chart 1 - Medicaid/Non-Medicaid Services[2]

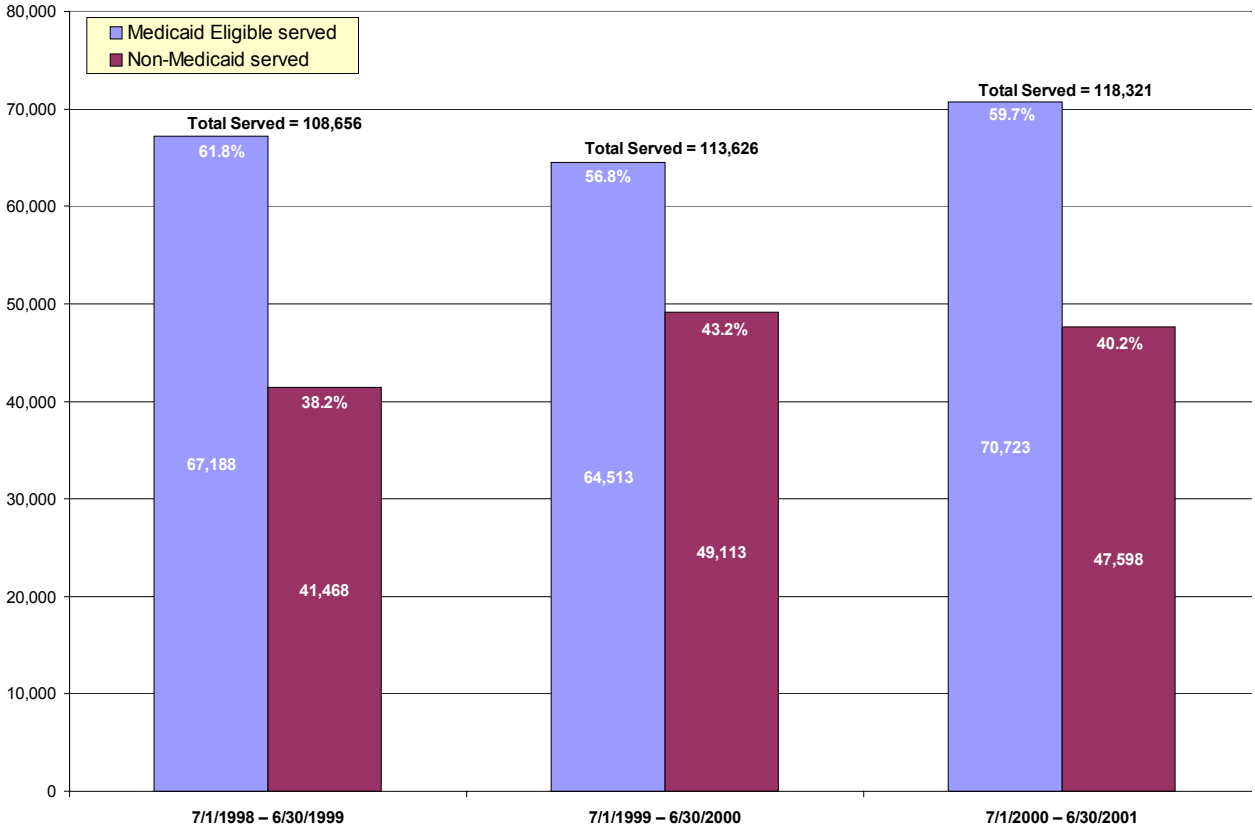
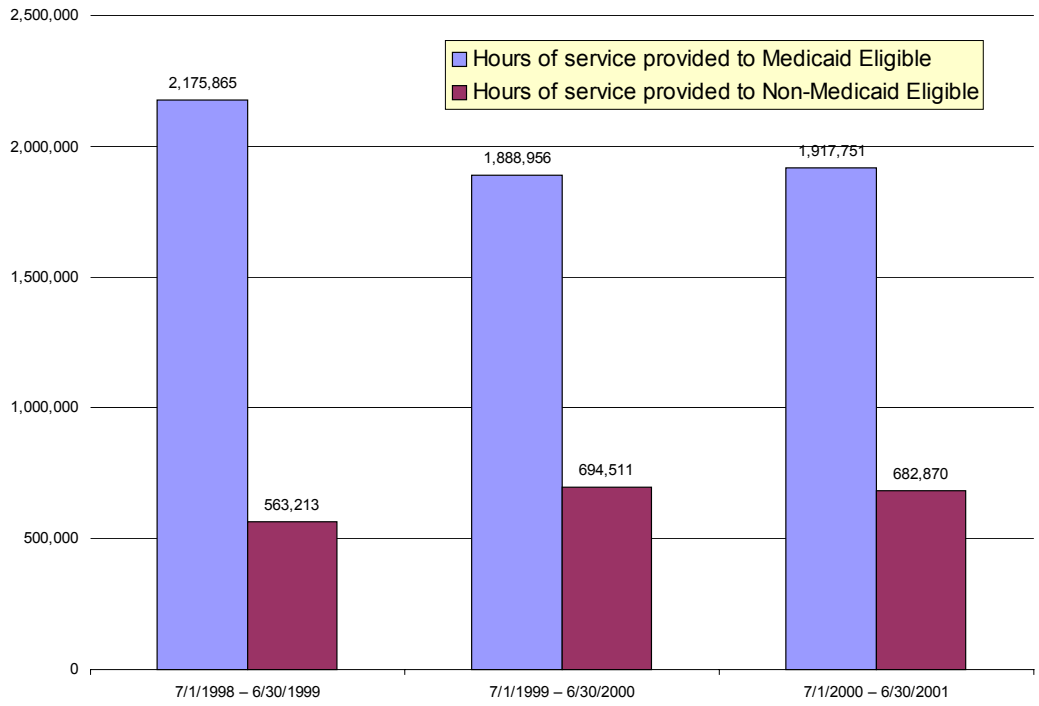


Chart 2 shows Medicaid eligible people receive over 75 percent of service hours delivered. Some consumers receive non-acute services. These tend to be minimal hours as would be consistent with a mental health evaluation. Non-Medicaid eligible persons receive less than 25 percent of the service hours delivered. The non-Medicaid eligible persons being seen by the RSNs are

[2] Client counts for Medicaid/Non-Medicaid breakouts may not equal 100% overtime as eligibility may change during the timeframe.

mostly crisis and, on average, receive less than fifteen hours of service per year.

Chart 2 - Services Hours



Some consumers tend to be customers of other human service programs as well as of mental health, (see Chart #3). Many children utilizing mental health services are clients of the Medical Assistance Administration, Children's Administration, and/or Juvenile Rehabilitation Administration. Many adults accessing services are also involved with substance abuse, aging or the criminal justice system. Additionally, many patients at the state hospitals are elderly or developmentally disabled. There is an increased need to collaborate among service systems to ensure appropriate treatment of each consumer.

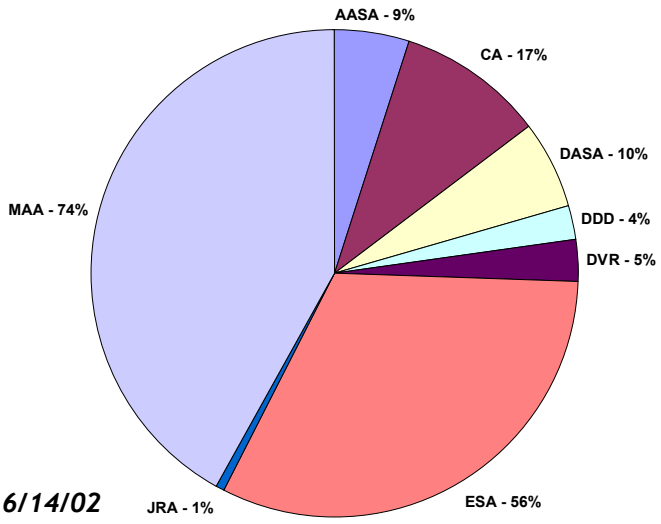
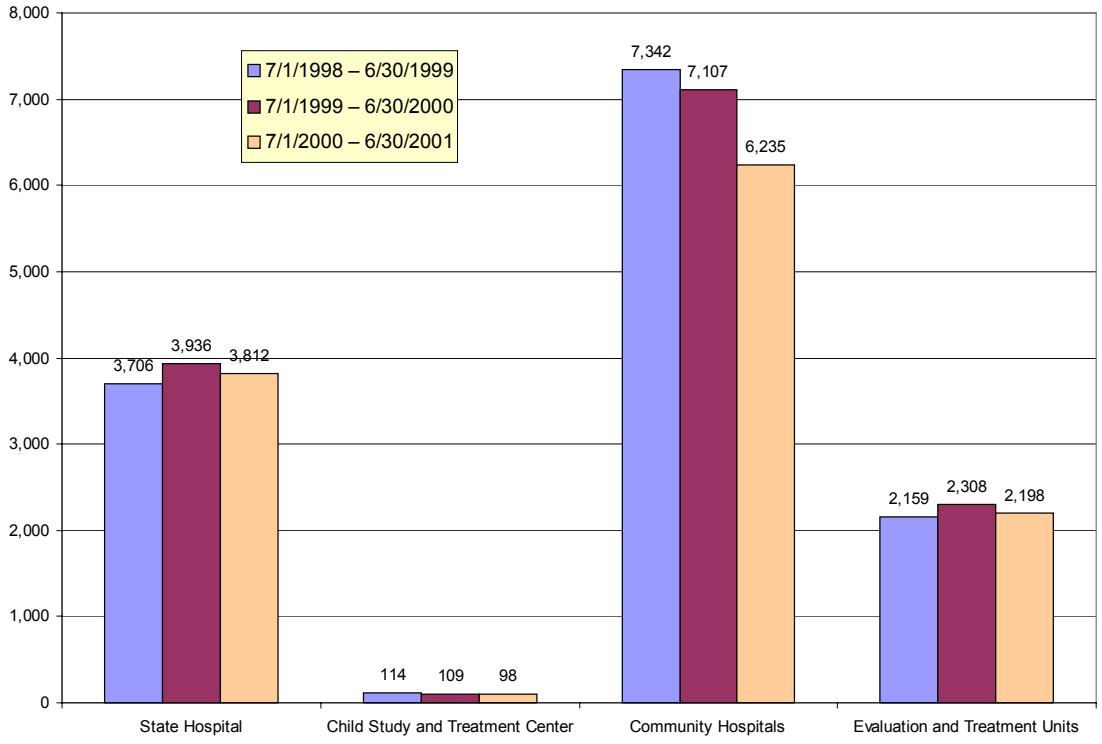


Chart 3 – Percentage of Mental Health Consumers receiving services from other DSHS Programs (FY2000)

Specific groups of mental health consumers are requiring more specialized treatment geared toward ensuring their recovery. Recent court decisions have placed emphasis on treating people in the most appropriate setting, rather than placing persons in state hospitals for lack of a more appropriate placement. This most clearly affects developmentally disabled clients and others who are no longer benefiting from state hospital inpatient level of care.

Chart 4 - Individuals Receiving Inpatient Services



Discussion of Major Partners

The Mental Health Division (MHD) is actively working to strengthen relationships with all partners in the mental health system. Major partners include the Regional Support Networks, consumers, families, community mental health providers, state hospital patients, labor unions and allied systems. Allied systems include formal systems such as the Children's Administration, Aging and Adult Services Administration, Division of Alcohol and Substance Abuse, Division of Developmental Disabilities, Office of Superintendent of Public Instruction, and Department of Corrections to name a few. However, within the mental health system, other community resource programs such as churches, foodbanks, homeless shelters and the YMCA and YWCA are often utilized. The mental health system also relies on the use of support systems such as friends and neighbors. Consumers and their families are represented on several MHD advisory groups and provide direction and feedback regarding the mental health system. The MHD's Office of Consumer Affairs supports a Consumer Round Table and a Parent Council which provide direct input to the division's director. Additionally, the division has contracted with a consumer and a parent to participate in the on-site monitoring of the Regional Support Networks and their provider network.

Consumers and family members make up 51 percent of our state mental health advisory council (MHAC). This committee, as do all others, includes representatives who are advocates for children and for older persons with mental illness, RSNs, service providers and allied systems. The MHAC has a very active role in establishing and monitoring the federal block grant plan submitted to the Center for Mental Health Services at the Substance Abuse Mental Health Services Administration. They and their subcommittees—Children, Family and Youth, Ethnic Minority, Sexual Minority, and Older Adults—have set priorities for next year, are focusing their efforts on best practice and stigma reduction, and provide valuable input and insight to the MHD.

MHD staff meets regularly with RSN administrators and assures there is representation from the RSNs on any committee established to change, establish, or set policy. These committees also include providers, consumers, parents and family advocates and, at times, allied system partners. Topics for discussion range from performance indicators to Washington Administrative Code changes.

MHD meets with the Washington Community Mental Health Council, a group representing some community mental health centers that provide services under subcontract with the RSNs. The MHD also seeks and receives input from community mental health centers that do not belong to the council but who subcontract with the RSNs.

As part of quality management, there have been three MHD sponsored System Improvement Groups (SIG) that met for specific tasks. The (SIG)—a group of stakeholders representing consumers, parents, family advocates, community mental health centers (both council and non-council members), Washington Institute for Mental Illness Research and Training (WIMRT), Regional Support Networks and MHD—is divided east/west and has no duplicative service area representation. SIG recommendations have been incorporated into the division's quality management plan, and into planning, policy, and contracting activities. Using the foundation established, the SIG may refine additional recommendations in the future.

MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee (CODIAC)—a committee of providers from mental health, chemical dependency, other cross-systems and consumers. This group has been in existence for approximately twelve years and addresses co-occurring mental illness and substance related disorders. The two divisions often engage in joint studies and are currently developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

Inpatient Roundtable—a technical assistance group comprised of staff from MHD, the Medical Assistance Administration, RSNs and community hospitals—meets on a routine basis to discuss various issues that arise.

The MHD received an annual $20,000 grant for three years beginning in 2001 to design and implement cross-system training with the Aging and Adult Services Administration. The training focuses on residential providers and the development of cross-system crisis plans with multiple steps that can be utilized prior to calling the crisis line. Training will also include presentations by individuals who have first-hand knowledge regarding local systems such as when to call the crisis line and what to expect from them. In addition, through federal block grant funds, there is a small amount of funds that will assist in providing this training.

Over the last biennium, MHD and the Division of Developmental Disabilities (DDD) conducted joint training. Attended by 300 individuals at 9 statewide training sites, Phase 1 training targeted an audience of mental health and developmental disabilities clinicians/administrators. The goal was to provide training in overall systems. The focus of mental health was on structure, laws governing the system, and crisis access with a local system introduction. The focus of DDD was on client-eligibility, programs, and access. Phase 2 training held at 10 statewide training sites included an audience of residential and employment/vocational providers. Averaging 60-70 people per site, this training focused on how to provide mental health treatment for people with developmental disabilities and how to write and implement cross-system crisis plans. In addition, phase 2 funded a track at the Behavioral Health Conference

and included national speakers and presenters. The Division of Developmental Disabilities has received funding for phase 3 training.

The Mental Health Division continues to recognize that many consumers served by other DSHS programs have mental illness and recognizes that these individuals should also be served by the mental health system. To ensure that these individuals have their full needs addressed, the division continues to pursue a strategy that strengthens collaboration and service delivery between systems and programs.

Financial Plan Assessment

Overall funding within the Mental Health Division has not kept pace with health care inflation in recent years. Funding increases due to rising Medicaid caseloads have been offset by reductions implemented for a variety of reasons. This static funding picture has created a general sense that the mental health system in Washington State is underfunded, and some Regional Support Networks have expressed concerns about whether or not they can continue to operate the mental health system in their catchment area. In addition, any new requirements implemented by federal or state authorities are vigorously opposed by RSNs, unless funding is provided to implement and sustain them.

The community mental health system is funded under a capitation arrangement, with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment areas. Funding provided is not identified to specific clients, nor is it specified for certain services or programs. RSNs are directed to accomplish all requirements in the contract with the overall funding they receive. Unfortunately, the Mental Health Division is unable to clearly identify where funds are being spent, how much is spent on certain client groups, and whether funds provided are sufficient to accomplish the goals set forth in statute, rule and contract. This has led to several cuts in RSN funding without accompanying changes in programmatic expectations. Expectations from other programs requiring services for persons with mental illness in their caseload are actually increasing. Each program is asking the mental health system to step up services to persons identified with mental or behavioral disorders. Funding provided to RSNs not specifically identified as spent on mental health direct services is at risk of being cut from the budget.

In the state hospitals, similar issues exist. State hospitals are funded at a level tied to "funded capacity" or census. The adult hospitals risk overexpenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. State hospitals also encounter resistance from the community if they attempt to refuse civil admissions: a policy instituted since the February 2001 earthquake. State hospitals overall are able to keep expenditures within allotted limits as long as census remains relatively within funded levels, but the ability to collect revenue from Medicare, Medicaid and private insurance for patients in the hospital is tenuous. A great deal of emphasis has been placed on revenue collection in the past couple of years, increasing overall collections. These efforts have also shown the need for clear supporting documentation for revenue and the need for an integrated revenue collection and accounts receivable system.

To deal with these issues, the MHD is conducting studies to examine need within the community system and is continuing to identify enhancements at the state hospitals that will increase revenue collection. The focus of one study is on the need for inpatient capacity for persons with mental illness and the appropriate capacity of state hospitals. An actuarial study will be conducted to identify the overall funding needs of community managed care programs. The division continues to ensure that state hospital billings are compliant with federal rules for reimbursement. Financial reporting requirements from the RSNs are being enhanced to ensure that funds spent and allocated on certain client groups are appropriately reported to the legislature and to other stakeholders.

As a result of participation in the Sixteen-State Pilot Indicator Project and the 2001 JLARC report, the MHD is moving toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the division, RSNs, and providers spent considerable time updating and revising the data dictionary to improve data reporting. This shift may be hampered by new federal requirements placed on managed care entities as a result of the Balanced Budget Act (BBA) of 1997 and by some reporting requirements of the Health Insurance Portability and Accountability Act (HIPAA). Both of these federal requirements, with primary implementation in SFY 03, will take continued planning, designing, training, implementation time, funding, and effort.

Goals, Objectives, Strategies and Performance Measures

GOAL #1

The appropriate level of service is provided in the right setting in a timely manner.

Objective #1: Create and use a standard set of methods for screening, assessment, and authorization of services and standard level of care.

STRATEGY - Charter a Systems Improvement Group to develop the standard methods of screening, assessment, and authorization of services, and the standard levels of care.

1. Review literature and national requirements and standards of accrediting bodies, other states, and national organizations (NTAC, NASMHPD, TAC, NCQA, CARF, JCAHO, and COA).
2. Review RSN level of care standards for commonality, strengths and scope.
3. Review assessment methods and level of care standards used by mental health managed care companies e.g., Magellan and PsychCare.
4. Evaluate methods developed to make certain they address the unique needs of children, adults, older adults, persons with co-occurring disorders, and other special populations.

STRATEGY - Develop early intervention and prevention services.

1. Determine service focus groups within population groups (e.g., 0-5 year old youth and their families, street kids, home-bound older adults, the homeless).
2. Review use of EPSDT screening and subsequent follow-up.
3. Consider disease management studies of physical/mental health co-morbidity and review MAA contracts.
4. Review literature and best practices.
5. Assess cost effectiveness of early intervention vs. long-term care.
6. Promote responsive and effective crisis intervention by developing best practice guidelines beyond CDMHP protocols.

STRATEGY - Monitor statewide services to promote best practices.

1. Document and expand current and future innovations.

2. Showcase RSNs with effective Utilization Management.
3. Review models (e.g., wrap-around/individualized and tailored care, PACT/ACT) for maintaining more people in community, use as statewide standard, and be clear on expected outcomes.
4. Develop common access standards for getting into care as well as continuing care based upon common assessment methods.
5. Review timeliness issues for post-discharge care, prompt intake, access to medication assessment and prescription, and termination of services after 'no shows.'
6. Collaborate with DASA to identify best practices for treating clients with co-occurring disorders.

Performance Measure: **A common statewide standard set of methods for screening, assessment, and authorization of services and standard level of care developed by June 30, 2004.**

Objective #2: Know who we serve and who gets served first.

STRATEGY – Develop department request legislation to establish clear prioritization of clients.

1. Continue crisis response system for any person in need in Washington.
2. Review current state and federal statutes pertaining to non-crisis services to determine where clarification is necessary.
3. Develop DSHS and CMS support for clear prioritization of persons receiving services within available resources.
4. Educate the legislature on the issue of mental health as a growing and under funded safety net.
5. Develop request legislation.
6. As part of the levels of care development operationalize revised statutes.

Performance Measure: **Department request legislation to establish clear prioritization of clients developed for the 2005 legislative session.**

Objective #3: Establish appropriate use and capacity of state psychiatric hospitals and promote service alternatives in communities.

STRATEGY – Move state hospital patients to less intensive levels of service in communities when appropriate.

1. Examine admission criteria.
2. Improve discharge planning.

3. Develop more effective use of funding resources for hospital patients and make improvements toward their timely discharge.
4. Provide training to increase hospital staff knowledge of community alternatives to hospital care.

STRATEGY - Increase community support, residential, housing, and employment services.

1. Conduct an assessment of current community services.
2. Conduct a needs assessment and evaluate needs assessments from earlier biennia.
3. Establish more alternatives to hospital placement (e.g., E&T facilities, nursing facilities and boarding homes with capacity to serve, Adult Residential Rehab Centers, and/or Assertive Community Treatment).
4. Introduce RSN/MHD contract terms to promote increased community service capacity.

Performance Measures: **Establish state psychiatric adult hospital census capacity goals based on results of an analysis of need and implement capacity changes in FY 05 through FY 09 to match results of the analysis.**

Identify two new contract terms for FY 04-05 RSN contract that create an incentive to treating consumers in their communities as opposed to inpatient hospitalization.

GOAL #2

Consumers are involved throughout the system.

Objective #1: Communicate twice yearly with all consumers.

STRATEGY - Publish provider report cards.

STRATEGY - Publish survey reports.

STRATEGY - Develop, publish, and mail informational brochure with an MHD reply card directly to consumer.

STRATEGY - Develop an Office of Consumer Affairs (OCA) MHD web page.

1. Provide training to consumers in use of MHD web site and OCA web page.

Performance Measure: **Two direct communications shared with consumers each fiscal year in FY 04 through FY 09.**

Objective #2: Involve consumers in all program and planning design.

STRATEGY – Further define the role of consumers in quality management activities within MHD, state hospitals, RSN, CMHC, and CLIP.

1. Showcase good examples of consumer involvement.

Performance Measure: **Consumers serving on Quality Management Committees throughout the system by June 30, 2005.**

Objective #3: Involve consumers in their recovery and treatment planning.

STRATEGY – Move towards a recovery model whereby the consumer acts in partnership with the service provider in developing a service plan.

STRATEGY – Promote integral involvement of families in the treatment process.

STRATEGY – Increase programming and recreational activities for state hospital patients during evening and weekends to help patients gain social, physical, and psychological growth.

STRATEGY – Consider amendments to Chapter 71.24 and 71.05 RCW to clearly state the rights of consumers.

Performance Measures: **By June 30, 2004, 90 percent of consumer cases reviewed in the previous provider licensing review cycle will have an individualized treatment plan, developed in collaboration with the consumer, within 30 days of the initiation of community support services.**

By June 30, 2006, 70 percent of consumers have their treatment goals written in their own words.

GOAL #3

Persons with multiple-system needs receive coordinated care.

Objective #1: Improve formalized service delivery agreements with other DSHS administrations and allied departments.

STRATEGY – Develop Memoranda of Understanding or working agreements to share with the field including requirements, confidentiality, documentation, filing, and budgeting.

1. Clearly spell out in intra-agency and inter-agency agreements, including data sharing agreements, the expectation of each division and/or department working with multi-system consumers.
2. Make staff aware of intra agency and inter agency agreements and ensure periodic review.
3. Increase and improve discharge planning from inpatient settings for multi-system consumers.

STRATEGY – Community Mental Health Centers and RSNs participate in A-Teams.

STRATEGY – Expand cross-system care coordination efforts within DSHS and with OSPI, DOC, and other relevant agencies.

Performance Measures: **RSN participating on all existing "A Teams" by June 30, 2004, and every year thereafter.**

Memoranda of understanding developed and implemented by June 30, 2004.

Objective #2: Increase number of clients served under joint treatment plans.

STRATEGY – For children and older adults, require through contract, that service protocols be developed with Children's Administration and Aging Adult Services Administration.

1. Review and address barriers identified through the development of protocols and through RSN reports to the MHD.
2. Review and address barriers discovered through performance-based reviews.
3. Review current law, administrative rules, and administrative policies of each agency to determine solutions to barriers and possible needed changes.

STRATEGY – Determine population groups needing risk management, to include high utilizing and high cost consumers.

1. Identify RSNs with high percentage of high utilization and high cost services.
2. Require targeted RSNs to develop an action plan for these populations, to include on-going monitoring and evaluation.
3. Require targeted RSNs to include this action plan in their Quality Improvement program.
4. Work in collaboration with RSNs to develop statewide population risk management practices.

STRATEGY – Provide training on joint treatment plan requirements.

STRATEGY – Explore blended and braided funding options.

Performance Measure: **Increase the number of clients served under joint treatment plans by 10 percent in FY 06, and by an additional 10 percent in FY 08.**

GOAL #4

Business practices accommodate a changing environment.

Objective #1: Provide employee training.

STRATEGY – One hundred percent of required training will be completed within required time lines.

1. Assign one staff to monitor, to track, and to report the status of individual employee training.
2. Ensure that individual training plans are created in connection with the employee evaluation process and with new employee procedures.

STRATEGY – Identify training opportunities on new federal requirements and ensure that at least one staff person attends.

STRATEGY – Identify training opportunities in information systems software and data retrieval methods.

STRATEGY – Offer at least one Quality Management and one best practices training to MHD staff.

STRATEGY – Invite allied systems to quality and best practices training and other educational opportunities.

Performance Measures: **All employees new to MHD will have scheduled and completed new employee orientation within three months of their hire date with MHD.**

One hundred percent of required training is completed within required time frames for each fiscal year, 2004 – 2009.

Objective #2: Implement an improved risk management program.

STRATEGY – Ensure that the policies and procedures manual is up-to-date and revise as necessary.

1. Ensure that Department e-mail and Internet policies are communicated to and understood by Division staff.

STRATEGY – Define scope of and conduct a risk management review of Division programs in order to identify risk mitigation activities that should be implemented.

1. Implement new federal regulations in a cost-effective manner, including BBA and HIPAA.
2. Maintain focus on improvements regarding work place safety at the state hospitals.

STRATEGY – Continue to implement compliant billing practices at the state hospitals.

1. Improve census tracking, utilization review processes, communication with the Finance Division, and planning for a new billing and collections system.

STRATEGY – Offer training to RSNs and providers on consumer rights, co-occurring disorders, and promoting the management of one's own care.

1. Address advanced directives for psychiatric care, disenrollment, and fair hearings.
2. Address best practices in treatment of individuals with co-occurring disorders.

Performance Measures: **Complete a risk management review of the mental health program by June 30, 2005.**

Training sessions are offered to RSNs and providers at least once in FY 05, in FY 07, and in FY 09.

Objective #3: Improve project management.

STRATEGY – Conduct future planning to identify major projects and initiatives to be completed and assign project management staff.

1. Develop a standard reporting mechanism to MHD management team for major projects.
2. Implement an improved policy on monitoring the progress of major projects.

Performance Measures: **Standard reporting mechanism for MHD management is developed and implemented by June 30, 2004.**

Policy on monitoring the progress of major projects is complete and implemented by June 30, 2005.

Objective #4: Examine the structure of the community mental health system.

STRATEGY - Complete an actuarial study to provide information on the effect of changes in system structure on program financing.

STRATEGY - Create a workgroup to explore the programmatic and financial impact of changing the system structure.

1. Examine current law and rule to determine revisions needed to change the system structure.
2. Conduct a risk management review of changing the system structure.

Performance Measures: **Third party actuarial study of rates paid, funding distribution, cost effectiveness, and managed care to fee for service completed and reported upon by November 30, 2003.**

Workgroup convened to examine the impact of changing the community mental health structure completes its work and issues a report by June 30, 2004.

GOAL #5

Data drives decisions.

Objective #1: Increase dissemination of information throughout the mental health system.

STRATEGY - Increase access to information for all program, planning, fiscal and management personnel.

1. Increase information dissemination throughout MHD headquarters with multiple short reports.
2. Maintain "ad hoc" reporting system to all desktops, train all staff to use system, and convene focus groups to identify information needed.

STRATEGY - Finalize and distribute "Annual Performance Indicator Report" to MHD staff, RSNs, providers and stakeholder groups.

STRATEGY - Modify MHD web site to increase usability by the public.

Performance Measures: **"Hits" to MHD ad-hoc system increase by 5 percent each year FY 04 through FY 09.**

Update and advertise "new and improved" MHD website in FY 04.

Objective #2: Develop an information system that integrates quantitative and qualitative data across the mental health system.

STRATEGY – Use MHD's HIPAA compliance plan to improve statewide data consistency, justify data reporting, and strengthen core data sets.

STRATEGY – Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement reviews.

STRATEGY – Build on existing information systems to incorporate and integrate consumer outcomes database.

STRATEGY – Build on existing information systems to incorporate and integrate other qualitative data (e.g.; OCA, QA&I, Ombuds, and P&P).

STRATEGY – Build reporting module for integrated data system.

1. Design user friendly query system for MHD staff.
2. Provide and maintain desktop access to query system for all MHD staff.

Performance Measure: **Integrated data system functional by FY 06, and reporting module operational by FY 07.**

Objective #3: Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

STRATEGY – Finalize and distribute "Annual Performance Indicator Report" to MHD staff, RSNs, providers and stakeholder groups.
STRATEGY – Develop consensus within MHD about goals/benchmarks for individual performance indicators.

1. Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.

STRATEGY – Develop positive incentive system for RSNs following JLARC recommendations.

1. Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

Performance Measures: **Goals and benchmarks created for all performance indicators in the Annual Performance Indicator Report by June 30, 2005.**

An incentive system for RSNs following JLARC recommendations developed by June 30, 2006.